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FARM LABOR, REPRODUCTIVE JUSTICE: MIGRANT WOMEN FARMWORKERS IN THE US

Charlene Galarneau

ABSTRACT

Little is known about the reproductive health of women migrant farmworkers in the US. The health and rights of these workers are advanced by fundamental human rights principles that are sometimes conceptually and operationally siloed into three approaches: reproductive health, reproductive rights, and reproductive justice. I focus on the latter framework, as it lends critical attention to the structural oppression central to poor reproductive health, as well as to the agency of communities organizing and leading efforts to improve their health. I review what is known about these women's reproductive health; identify three realms of reproduction oppression affecting their reproductive health: labor/occupational conditions, health care, and social relations involving race, immigration and fertility; and then highlight some current efforts at women farmworker-directed change. Finally, I make several analytical observations that suggest the importance of the reproductive justice framework to broader discussions of migrant worker justice and its role in realizing their right to health.

INTRODUCTION

Summer 1978 in rural Colorado: Luz was 14 years old, working in the melon fields, and pregnant. Her abortion may be read as evidence of access to legal abortion services, or it may be read as a lack of access to comprehensive reproductive health services, including contraception and education. Alternatively, when understood through the lens of reproductive justice, Luz's story reveals the breadth of inequities—social, political, and economic—that compromised her reproductive health then, and that continues to compromise migrant farmworker women's reproductive health today.

One in four or five farmworkers in the United States today is female.¹ Here, I explore what reproductive justice might mean for these women and adolescents, and in particular, for those who are migrant farmworkers. I begin with a methodological reflection prompted by philosopher Alison Bailey's concern for epistemic honesty as expressed in her challenging question, "How much can I know about [migrant farmworker women] from where I sit?"² Given the dearth of reliable research on farmworker health, the partial and often misleading representations of farmworkers in the popular media, and the "distorting effects that Western feminism can have on third-world women," what can I reliably "know" about migrant farmworkers "from where I sit?"³ Although never a migrant farmworker, I did sit, or more accurately, stand for two summers as a young teen working in the shade tobacco barns and fields of western Massachusetts. I met Luz (not her real name and de-identified in other ways as well) during one college summer that preceded my years of working with migrant and seasonal farmworkers in the late 1970s and early 1980s in various educational and administrative capacities, mostly with migrant/community health centers in rural Colorado. Among my notable experiences, I directed a migrant mobile clinic program, testified at a Colorado State legislative hearing on the impact of poor field sanita-

tion on farmworker women and children, and served on the National Advisory Council on Migrant Health (NACMH) from 1988-1992.⁴ These experiences do not make me an expert on farmworkers' lives, but they motivate my desire to understand the injustices I witnessed, as well as my continued commitment to issues of farmworker justice. This article draws on sources known by virtue of these experiences, on available empirical data, and importantly, on the words and practices of migrant women farmworkers.

The health and rights of migrant women farmworkers are strongly endorsed by fundamental human rights principles that recognize a right to health—including sexual and reproductive freedom—as interdependent with other rights and an array of underlying social conditions.⁵ Following a demographic overview of US women farmworkers and their health status with particular attention to reproduction, I engage the reproductive justice framework to begin to understand the complex of reasons for these women's relatively poor reproductive health and why we might call it unjust. I identify 1) social inequities that produce reproductive oppression, 2) aspects of this oppression experienced by migrant and other farmworkers, and 3) farmworker-directed strategies for change. I explore this reproductive justice framework in relation to reproductive health and reproductive rights frameworks, and end with analytical observations suggesting the justice framework's importance for broader discussions of migrant worker health, rights, and justice.

MIGRANT FARMWORKER WOMEN: DEFINITIONS, DEMOGRAPHICS, AND HEALTH DATA

Who is a farmworker, and in particular, a migrant farmworker? Definitions in the US vary in common usage and by government agency. For the purposes of migrant health centers supported by the US Department of Health and Human Services (DHHS), a "migratory agricultural worker" is "an individual whose principal employment is in agriculture, who has been so employed within the last 24 months, and who establishes for the purposes of such employment a temporary abode."⁶ "Temporary abode" serves as a proxy for worker migration that occurs either within the US or internationally—most often from Mexico to the US. "Seasonal" agricultural workers do similar labor as migrants but live close to their work year-round.⁷ In practice, migrant health clinics serve both migrant and seasonal farmworkers including

employed, retired, and/or disabled farmworkers—and their family members. As such, when addressing migrant health, the terms "migrant farmworkers" and "migrant and seasonal farmworkers" typically refer not only to current workers, but also to this wider group of workers and their families.

In contrast, the US Department of Labor (DOL) defines migrants as currently hired workers "who travel at least 75 miles during a 12-month period to obtain a farm job"; this is a partially overlapping and significant subset of DHHS-defined migrants.⁸ This narrower definition is used in the DOL's National Agricultural Worker Survey (NAWS), a face-to-face survey of hired farmworkers that produces demographic and employment data. The Department of Agriculture (USDA) also reports on "hired farmworkers," a group similar to, though not precisely the same as, the NAWS' definition of hired workers.⁹ Given these varied definitions, it is not surprising that population estimates for the US farmworker population range widely, from the USDA's 1.01 million hired farmworkers, to 1.8 million workers based on NAWS data, to 3 to 5 million farmworkers in the health literature.¹⁰

NAWS produces the most detailed national demographic data about employed farmworkers. The most recent national NAWS report, published in 2005 and based on 2001-2002 survey data, finds that 21% of hired farmworkers were women, and that these women were 33 years old, on average.¹¹ Of these women, 71% were non-migrant workers, 59% were married, and 25% were "unaccompanied," that is, lived apart from parents, spouse, and children.¹² Also, 39% were "unauthorized" to work (also known as "undocumented"), 33% were US-born, 24% were legal permanent residents, and 3% were naturalized citizens.¹³

Of all workers interviewed in the 2001-2002 NAWS, approximately four of five (81%) reported Spanish as their native language and the average highest grade of completed school was the seventh grade.¹⁴ The average total family income was \$15,000-\$17,499, with the average individual income being \$10,000-12,499.¹⁵ As for national origin, 75% migrated from Mexico, 2% from Central America, and 1% from other countries.¹⁶ Similarly, the National Center on Farmworker Health (NCFH) reports that 83% of US farmworkers are Mexican-American, Mexican, Puerto Rican, Cuban, and from central and South

America, whereas the rest are African-American, Jamaican, Haitian, Laotian, Thai, or others.¹⁷

More recent NAWS data from California (versus the nation) adds empirical evidence of the shifting farmworker population in that state, as noted by many researchers.¹⁸ These 2003-2004 California data show that 27% of employed farmworkers were women (vs. 21% nationally), 16-20% of all farmworkers reported being indigenous Mexicans and 94% were foreign-born—nearly all in Mexico (vs. 75% nationally). Of the California women farmworkers, 18% were unaccompanied (vs. 25% nationally), 72% were married (vs. 49% nationally), and of those married, nearly all (98%) lived with their spouses.¹⁹ More than two-thirds (69%) were mothers, and most mothers (95%) lived with their children.²⁰ Other than these few demographic, marital, and parental status findings, little gender analysis is available in either the national- or state-specific NAWS reports.

Notably, as these NAWS reports and the following data show, women farmworkers are a highly diverse group—migrant and seasonal, US-born and foreign-born—and they reflect the full spectrum of immigration statuses. They live in families and communities that are likewise diverse. As such, it is rarely possible to accurately and neatly segregate migrant from seasonal, and undocumented from documented women farmworkers. Where migrant-specific information is known, it is included here.

Reliable population-wide data on the health status of farmworkers are virtually nonexistent. State and local studies exist, although many are outdated and/or narrow in scope and none approaches a comprehensive population-wide picture of farmworker health.²¹ This stark research deficit limits both public health efforts and health care providers' ability to properly diagnose and treat farmworkers. This deficit also leads to the frequent generalization of state and local studies to the entire US farmworker population, as well as the regular recycling of dubious data: for example, the common claim that the average life expectancy for migrant farmworkers is 49 years was found to be unsubstantiated two decades ago, but this "fact" continues to circulate.²² Such data misuse contributes to a sense that we know more about farmworker health than we actually do.

Disturbingly, some contemporary research on

farmworker health simply neglects gender and/or women. A recently published health assessment of New York farmworkers collected no data by gender.²³ A 2010 survey report on the health of California farmworkers 1) describes the survey sample as "comprised mostly of young Mexican men" despite the fact that 36% of the sample was women, 2) mentions that women were interviewed on their risk behaviors related to reproductive health but reports no related findings, and 3) reports on male but not female access to toilets and water for drinking and washing, despite well-known differential risks by gender.²⁴

Data specific to farmworker women's reproductive health is even more limited in quantity, quality, and scope, but what is available suggests a morally and medically troubling situation. A 1987 study of Colorado migrant farmworkers found that among sexually active women, 24% had been sterilized; one-third had had one or more miscarriages or abortions; and one in eight had an infant die within the first year of life.²⁵ The Centers for Disease Control and Prevention (CDC) analyzed 1989-1993 data in its Pregnancy Nutrition Surveillance System collected from more than 4800 migrant farmworker women and found that just over half (52%) had gained less than the recommended weight throughout their pregnancies, compared to 32% of non-migrant women.²⁶ Larson, McGuire, Watkins, and Mountain cite studies from the late 1980s finding that 42% of migrant women enrolled in prenatal care in their first trimester of pregnancy, compared to 76% of women nationally.²⁷ A more recent health care utilization study of Latina farmworkers in Michigan showed their relatively low use of reproductive health services, including contraception and protection from sexually transmitted infections.²⁸

This data landscape means that it is currently impossible to accurately describe the reproductive health status of US women farmworkers as a group, not to mention migrant farmworkers specifically. That said, what we do know suggests that migrant farmworkers have relatively poor reproductive health. According to the reproductive justice framework, this situation is not simply unfortunate, but rather the result of reproductive oppression.

REPRODUCTIVE JUSTICE: IDENTIFYING REPRODUCTIVE OPPRESSION

In the mid-1990s, black women health activists coined the term “reproductive justice” as an alternative to the choice-centered reproductive rights movement that only partially addressed the experiences and needs of black women. Inspired by the human rights discourse of international activists at the Cairo International Conference on Population and Development, these US activists developed a vision of justice that responded to their understandings and experiences of reproductive oppression.²⁹ Now adopted, adapted, and articulated by dozens of groups in the US, reproductive justice has become a theoretical framework, a tool of ethical analysis, and an active movement for social change.³⁰

Echoing the World Health Organization’s expansive and aspirational definition of health, reproductive justice is defined as “the complete physical, mental, spiritual, political, economic, and social well-being of women and girls, based on the full achievement and protection of women’s human rights.”³¹ The SisterSong Women of Color Reproductive Justice Collective understands reproductive justice to be rooted in “the human right to make personal decisions about one’s life, and the obligation of government and society to ensure that the conditions are suitable for implementing one’s decisions.”³² Reproductive justice entails three specific rights: “the right to have children, not have children, and to parent the children we have in safe and healthy environments.”³³ As the Asian Communities for Reproductive Justice articulates it, reproductive justice “will be achieved *when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives.*”³⁴

In order to bring about this vision of reproductive justice and thus to fulfill these rights, the reproductive justice framework begins with the identification of elements of reproductive oppression, followed by the development of strategies to eliminate the conditions that enable this oppression. Reproductive oppression is understood as “the regulation of reproduction and exploitation of women’s bodies and labor” as “both a tool and a result of systems of oppression based on race, class, gender, sexuality, ability, age and immigration status.”³⁵ Furthermore, the control and exploitation of women is understood to be “a means of controlling entire communities – particularly low-income communities of color.”³⁶ In other words, social inequities produce reproductive

oppression that in turn reinforces social inequities. As such, “Reproductive Justice aims to transform power inequities and create long-term systematic change, and therefore relies on the leadership of communities most impacted by reproductive oppression.”³⁷ Elements of reproductive oppression are evident in Luz’s story:

Family poverty meant that Luz had little choice about working in low wage and relatively dangerous fieldwork without health insurance during summer months and some school weeks. She did not learn about sexuality, reproduction, or contraception in school, from her family, or from the health care providers she occasionally visited. She did not understand how pregnancy occurred until after she was pregnant. An evening migrant education program for teen workers included bilingual (Spanish-English) health screenings and meant that Luz had access to pregnancy testing. Luz and her mother agreed on Luz’s decision to end her pregnancy but withheld her pregnancy from her Luz’s father for fear of his reaction. The unusual presence that summer of a student health worker team with a mandate to expand health care services to migrant farmworkers meant that Luz had reproductive options beyond those typically available. That said, the services that Luz needed cost money and were three hours away by car. She had no money, no car, and no time off from work. This situation imperiled Luz’s physical and mental health and constrained her ability to make healthy decisions about her body and her reproduction.

Luz’s story illustrates ways that farmworker women’s reproduction, bodies, and labor are regulated, exploited, and controlled.³⁸ Macro-level forces at the national and international levels that variously affect all farmworkers importantly shape this individual experience of reproductive oppression. Economic and political conditions, immigration policies, and agricultural trends in the US, Mexico, and other countries interact complexly to “push” and/or “pull” farmworkers across national boundaries.³⁹ International trade agreements like the North American Free Trade Agreement impact income and job opportunities in all associated countries. US immigration policies, including the Bracero Program (1942-1965), the 1986 Immigration Reform and Control Act, and many more recent rules, have actively regulated border crossing, employer hiring, and immigrant legal status. Changing agricultural production and policies in the US have contributed to rural poverty, including farmworker poverty, in less recognized ways.⁴⁰ An adequate treatment of these macro-level policies is beyond the scope of this article, but it is important to recognize that

these broad policies regulate and compromise women's income, work, migration, health, and safety, and thus are critical elements of a comprehensive understanding of reproductive oppression. I focus next on three overlapping and interrelated clusters of more immediate aspects of reproductive oppression: labor/occupational conditions, health care, and social relations involving racism, immigration, and fertility.

Labor/occupational conditions

Agricultural laborers in the US earn low wages and have few, if any, job benefits. Female farmworkers earn less than male workers for several reasons: they work fewer hours, are sometimes paid less than men for the same work, and are occupationally segregated into lower paying "women's work" positions.⁴¹ Some employers refuse to hire or promote women and others have refused to give women benefits offered to men, for example, housing.⁴² The farm labor contracting system, in which workers are hired by farm labor contractors rather than directly by farm owners, obscures responsibility for such discriminatory labor practices.

Childcare is virtually never an employment benefit of agricultural work, and thus farmworker children either work in the fields, "play" around the fields while their parents work, or are cared for at home, usually by grandmothers, aunts, or siblings. Agricultural employers, like the employers of other transnational migrants, rely heavily on the unpaid caring labor of some women to make possible the work of other women and men, as employees. The farmworking mother "enters the workplace towing the older woman's labor behind her," note Griffith and Kissam.⁴³

These workplace realities challenge the common and deeply held belief that agricultural work is importantly "different" than other work and thus less in need of the government standards that regulate other worksites.⁴⁴ Arguing against the unionization of agricultural workers, an official of the American Farm Bureau Federation declared, "Conditions in agriculture are so different . . . that no union should be empowered to act as the exclusive bargaining agent of the workers employed by farmers."⁴⁵ This agricultural exceptionalism coupled with a rural romanticism—the myth that the "country" is safe, clean, and tranquil—helps sustain labor laws that exempt agricultural workers from regulations and safety standards that routinely protect other

workers. The National Labor Relations Act exempts agricultural workers from many of its protections, as does the Fair Labor Standards Act.⁴⁶ A United Farm Workers report sums up the problem clearly: "The absence of regulatory oversight, enforcement, and data about this [labor] sector leaves employers unaccountable to basic health and safety standards while leaving farmworkers vulnerable to abuse."⁴⁷

A wide array of occupational and environmental hazards, ranging from minor to life threatening, is associated with farmwork, and some have gendered consequences. The common lack of access to safe toilets in the fields dissuades many women from urinating for long periods throughout the work day, contributing to urinary tract and kidney infections, which are especially dangerous conditions for pregnant women. Simultaneously, farmworker women may become dehydrated from physical exertion, prolonged sun exposure, and a lack of clean drinking water.

A quarter-century ago, a landmark report by the Farmworker Justice Fund documented the occupational risks of farmwork, including injuries and death from farm accidents, acute and chronic pesticides exposure, respiratory problems, lack of safe drinking water and toilets, muscular-skeletal strains, heat-related illness or death, skin disorders, eye problems, and communicable diseases.⁴⁸ Regarding reproductive health specifically, the National Center for Farmworker Health reports that "prolonged standing and bending, overexertion, extremes in temperature and weather, dehydration, chemical exposure, and lack of sanitary washing facilities in the fields" can contribute to serious outcomes for the pregnant woman including the fetus.⁴⁹ A recent research review identifies the many reproductive effects of pesticide exposure, including spontaneous abortion and birth defects, though little of this research includes farmworkers as research participants.⁵⁰ One study of farmworkers found that some pregnant California farmworkers exposed to organophosphates, a common group of agricultural pesticides, bore children that, at age seven, had IQ scores seven points lower than those whose mothers had had little or no exposure.⁵¹ The inevitable chronic and sometimes acute exposure to multiple pesticides with unknown interactions suggests that farmworker women's reproductive health is likely far more compromised than we currently understand.

The migration component of farmwork invites special consideration in relation to reproductive health. Like most women in the paid work force, women farmworkers are primarily responsible for the domestic labor in their homes, including child and elder care, housework, and food-related activities. Unlike most employed women, migrant farmworker women are also largely responsible for the work of “establishing a temporary abode,” that is, migration. Domestic migration involves traveling long distances, often in crowded vehicles, with scarce funds for gas and vehicle repairs, and sometimes sleeping overnight on the roadside. Finding temporary and affordable housing in rural areas is difficult, and farmer-supplied housing is often expensive and marginally inhabitable due to cramped space, missing windows, screens, and door locks, and often poorly functioning and inconvenient kitchen and bathroom facilities. Packing and unpacking a family’s possessions and setting up a short-term household, often several times in one season, makes for an expanded “second shift” for women that vividly illustrates the gendered nature of migrant farmwork. International migration is also costly, especially for those who pay a “coyote” to smuggle them in, as women do in greater proportion than men.⁵² The border crossing is also risky due to heat, violence, and apprehension by immigration police.

An undervaluing of farmworking women’s work and agency is reflected in and reinforced by a common gendered assumption about migration: that males migrate to work and females migrate to follow males and other family members.⁵³ Although it is the case that many more Mexican males than females migrate to the US, Cardenas and Flores have shown that women also migrate largely for economic reasons.⁵⁴ Waugh’s recent study of Mexican immigrant farmworker women in California asked participants why they came to the US: “...80% mentioned the desire to escape poverty and earn money to support their families.”⁵⁵ Some women migrate to escape violence in their homes and home communities.⁵⁶ Post-migration settlement, like migration, is gendered and proportionately more women migrants want to settle permanently in the US due in large measure to gender equity gains.⁵⁷

Agricultural work is characterized by the rampant sexual assault and harassment of women, and this violence is not new. A 1993 study found that 90% of

farmworker women reported sexual harassment as “a major problem...in the work place.”⁵⁸ In Waugh’s report, 80% of 150 Mexican farmworker women working in California’s Central Valley reported experiencing sexual harassment.⁵⁹ Women routinely mask their bodies in layers of clothing, including hats and bandanas, to avoid sexual attention and harassment.⁶⁰ Women farmworkers are at risk while migrating, working in the fields, and living in their homes. Traveling long distances through rural areas in the US or Mexico, and/or through the US-Mexico border region puts women at risk for sexual violence by local police, the border patrol, “coyotes” or paid smugglers, and other immigrants.⁶¹ Once settled in a new home and job, women labor in often-isolated fields, canneries, and packing houses, and their travel to work in farmer or contractor supplied vehicles is risky due to predatory supervisors and field bosses. Women are reluctant to report sexual assault to legal authorities for many reasons: fear of workplace retaliation and job loss, powerful cultural taboos against speaking about sex, gender expectations of obedience and sexual service, ignorance of legal rights and appropriate legal processes, immigration status and fear of deportation, the lack of bilingual/bicultural services, and shame.⁶²

Reproductive oppression persists to the extent that women’s reproduction is affected by 1) poverty rooted in low wage, low benefit, and exploited labor, 2) the work of migration that adds significantly to women’s unpaid domestic labor, 3) hazardous work conditions, including sexual assault and pesticide exposure, and 4) weak labor and safety regulations limiting those hazards.

Health care

In the mid-twentieth century, migrant farmworkers were routinely denied access to publicly funded health care services due to local and state residency requirements.⁶³ The President’s Commission on Migratory Labor noted in its 1951 report, “Migratory farm laborers move restlessly over the face of the land, but they neither belong to the land nor does the land belong to them. They pass through community after community, but they neither claim the community as home nor does the community claim them.”⁶⁴ Bluntly stated, “The public acknowledges the existence of migrants, yet declines to accept them as full members of the community.”⁶⁵ The Commission

recommended that “...the Federal Government should share responsibility with the States for the development of a health program for migratory workers.”⁶⁶ In 1962, President Kennedy signed the Migrant Health Act that established funding for the Migrant Health Program.⁶⁷

Nearly four decades later, in 2010, 156 federally funded migrant health centers, many jointly funded with community health centers, operated more than 500 clinic sites across the US and served 862,775 farmworkers including family members.⁶⁸ These health centers offer comprehensive primary care services including routine reproductive health services to all patients regardless of health insurance status or ability to pay. Governed by community-based boards with at least 51% user membership, these centers meet only part of the farmworker population’s need for health care. DHHS estimates that its programs, including migrant clinics, “serve more than one quarter of all migrant and seasonal farmworkers,” leaving the majority of farmworkers without these services.⁶⁹ Public hospitals and public health departments, as well as some private providers also serve farmworkers, though little data exists regarding the volume, quality, and cost of this care.

Some migrant-specific needs are addressed through migrant outreach services including mobile clinics and promotoras, or lay-health advisor programs.⁷⁰ Promotoras are typically community-based women trained to provide educational and outreach services to their peers, including, for example, pesticide safety education, HIV testing, and social support for diabetes self-management.⁷¹ Innovative services providing continuity of care to pregnant migrants include portable medical records and a care management tracking system within the national network of health centers.⁷²

Numerous clinical, policy, advocacy, and training organizations support the efforts of migrant health centers. For example, the Migrant Clinician Network (MCN), the National Center for Farmworker Health, and the National Association of Community Health Centers work to expand access to, and the quality of, current health care services. As an advisor to the Secretary of Health and Human Services, NACMH produces annual recommendations on migrant health issues.

A major obstacle to health care for farmworkers is the lack of health insurance. Rosenbaum and Shin report that in 2000, 85% of farmworkers had no health insurance, 10% had private insurance, and 5% had Medicaid coverage.⁷³ The California NAWs survey in 2003-2004 showed that 70% of hired farmworkers had no insurance.⁷⁴ Of the insured, 50% were covered by their employer and 8% by their spouse’s employer, 35% by a government program, 29% paid for some or all insurance out of pocket, and 2% other.⁷⁵

Medicaid provides public insurance coverage for certain low-income persons, but there are many barriers to coverage for migrant farmworkers. Perhaps most obvious is the fact that many migrants reside in more than one state in a given year. Medicaid is a state-based program, and although it technically recognizes persons who live in a state for work as state residents, many state agencies administering the program do not honor this understanding.⁷⁶ Other significant barriers include 1) categorical eligibility requirements that exclude, for example, non-disabled childless working-age adults, 2) financial eligibility rules: the sometimes widely fluctuating month-to-month income of farmworkers works against eligibility in Medicaid’s monthly eligibility system, 3) immigration status requirements: except for very limited emergency Medicaid coverage, documented immigrants are not Medicaid-eligible for five years post-immigration, and undocumented immigrants are ineligible without exception, and 4) enrollment barriers: “inaccessible [application] site locations, long application forms, extensive verification requirements, and limited to no language assistance.”⁷⁷ Over the last 30 years numerous studies, recommendations, and policy efforts advocating the expansion of Medicaid eligibility rules to include more farmworkers have been made, but little has changed.⁷⁸

Federal health and social policy reforms have restricted access to health services for immigrants, and in particular, undocumented workers. The 1996 Personal Responsibility and Work Opportunity Reconciliation Act prohibits non-citizens from receiving publicly funded benefits, including health care, during their first five years in the US.⁷⁹ The 2010 Patient Protection and Affordable Care Act (ACA) expands insurance coverage to some uninsured persons, but undocumented immigrants continue

to be excluded from all federally supported health care insurance.⁸⁰ Documented immigrants in their first five years of US residence remain ineligible for Medicaid, but under ACA, they are now eligible for health plans available under the new state exchanges. This already highly restricted access to reproductive health care for farmworker women is exacerbated by recent policy and funding attempts to limit access to reproductive health services for all US women. The reduction in Title X funding for family planning services, the attempted closure of Planned Parenthood clinics, growing state restrictions on abortion, and the segregation of abortion services within ACA contribute to the health and health care inequities experienced by many women, and experienced disproportionately by low-income women, including farmworkers.

Additional obstacles to quality health care for farmworkers include the long-standing Hyde Amendment's prohibition of Medicaid funding for most abortions, the historical neglect of agriculture in the field of occupational health, the biomedical neglect of indigenous medical cultures, and the already-noted dearth of high quality, population-wide health research on farmworkers, and in particular on women farmworkers.⁸¹

Despite five decades of the Migrant Health Program, with its national network of hundreds of migrant health clinic sites, farmworkers continue to experience inadequate access to necessary health care services, and in particular to services that are culturally competent, responsive to patient mobility, and based on credible health research. Without a doubt, this health care context negatively impacts farmworker women's fertility and reproductive health in multiple ways.

Social relations: A "fearsome trinity" of race, immigration, and fertility

The contemporary US economic, political, social, and cultural context is rife with powerful stereotypes and discriminatory attitudes regarding immigration, gender, race, sexuality, and fertility that contribute to the reproductive oppression of farmworker women. Mexican immigrants have long been stigmatized as a threat to the US: to its economy, public health, public schools, public welfare, and the political and social stability of the nation as a whole.⁸² In public health in particular, xenophobia and racism have led to the characterization of Mexican immigrants as disease-

carrying outsiders likely to infect presumably healthy citizens.⁸³

This anti-immigrant sentiment combines with racism and sexism to target immigrant Latinas.⁸⁴ As Chavez notes, "Fears of immigrants' sexuality and their reproductive capacities are not new. Race, immigration, and fertility have formed a fearsome trinity for much of U.S. history."⁸⁵ He explains:

The "hot" Latina is one of two stereotypes generally applied to Latinas. They are either hypersexualized and hot seductresses or pure virginal girls or married women, selfless obedient wives and mothers. This latter stereotype is referred to as Marianismo, after the Virgin Mary, and is merged with the hot Latina stereotype into one hybrid image: the hypersexuality of the hot Latina combines with the abundant fertility and uncontrolled reproduction of the Mariana mother to produce the "Latina threat."⁸⁶

This "threat" portrays immigrant Latinas as "breeders" of "anchor babies," American citizen newborns who, as adults, might apply to bring family members to the US.⁸⁷ Pregnant Latinas are also targeted as "resource depleters" whose use of perinatal services drains health care resources needed by US citizens.⁸⁸

Together, the labor/occupational conditions of farmwork, the state of US health care for farmworkers, and pervasive and stigmatizing social relations interact to create a context that regulates, controls, and exploits women farmworkers; in short, a context of reproductive oppression.

REPRODUCTIVE JUSTICE: FARMWORKER-DIRECTED CHANGE

Though not always named as such, some farmworker women are doing reproductive justice work, with their principal strategies being community organizing and leadership development to enable community members to shift unjust power relations and oppressive social norms. Other efforts include building working alliances with related social justice organizations and shorter-term activities to address immediate needs in the community. At its best, this justice work is an inclusive and participatory process that focuses on the strengths of a community.

Creating structural change and challenging power inequities

For more than half a century, farmworker women have organized as active agents of social change, despite the serious obstacles posed by isolation, mobility, sexist norms, resistance from families and farmers, and poverty. Farmworker women have been involved in labor organizing, most notably in the United Farm Workers of America (UFW) since its inception in the early 1960s.⁸⁹ Opinions vary about whether unions like the UFW empowered women, re-inscribed conventional gender roles, or did both.⁹⁰ In any case, some farmworker women formed women's organizations, and in 1991 the first National Farmworker Women's Meeting took place in San Antonio, Texas. Nearly 50 Latina, African-American, Haitian, and Hmong farmworker women converged for this unique four-day gathering focused on community organizing, leadership development, and specific health concerns.⁹¹ In October 2012, Alianza Nacional de Campesinas (National Alliance of Farmworker Women) met in Washington DC "to launch a new national initiative dedicated to promoting economic justice, equality, health and safety for all U.S. agricultural workers."⁹²

Grassroots organizing by farmworker women continues today, although exclusively women's organizations are uncommon; exceptions include Mujeres Luchadores Progresistas (MLP) in Oregon and Líderes Campesinas (Farmworker Leaders) in California. Incorporated in 2001, MLP works to build economic independence for farmworker women as well as women's leadership and peer support. MLP grew out of PCUN, Oregon's farmworker union, when women members identified domestic violence and workplace sexual harassment as unaddressed problems of exploitation and injustice rooted in economic inequity and dependence.⁹³ "We believe there should be respect among workers. As a group of farmworker women, we will strengthen our pride, our dignity and advance our cause," says a MLP representative, and "While we address systemic and institutional sexism, we are careful not to approach the work in a way that would divide the family or isolate women from the very limited support or security they presently have."⁹⁴ MLP's holiday wreath-making sales contribute to their economic independence, and their radio program offers women's health information.

In 1988, Líderes Campesinas started as Mujeres Mexicanas, a local farmworker women's group. Four years later, the group expanded statewide; in 1997 it incorporated as Líderes Campesinas, and now has seven local campesina chapters across California.⁹⁵ Their mission is "to develop leadership among campesinas so that they serve as agents of political, social, and economic change in the farmworker community," and they do this through "capacity building, democratic decision-making, advocacy, peer training and leadership development as well as a mixture of traditional and innovative education, outreach and mobilizing methods such as house meetings, arts, and theatrical presentation at community venues."⁹⁶ Líderes Campesinas works with other farmworker advocacy organizations, government agencies, and private groups that support farmworker rights and together they address a wide array of labor and health issues including domestic violence, immigrant and worker rights, and pesticide safety.⁹⁷

The organizing work of Líderes Campesinas has been documented extensively by ethnographer Maylei Blackwell.⁹⁸ According to Blackwell, the women of Líderes Campesinas "create sources of empowerment from their bi-national life experiences and new forms of gendered grassroots leadership that navigate the overlapping, hybrid hegemonies produced by US, Mexican, and migrant relations of power."⁹⁹ Further aligning with the model of reproductive justice, "immigrant women's organizing challenges the racialized and gendered forms of structural violence exacerbated by neoliberal globalization and serves as an unrecognized source of transnational feminist theorizing."¹⁰⁰

Many other farmworker advocacy organizations also work for the structural change sought by reproductive justice, for example, labor unions/organizations, the Dolores Huerta Foundation, and Farmworker Justice. Wiggins has documented the efforts of farmworker organizing groups in North Carolina.¹⁰¹ Indigenous farmworkers in California have organized with significant women's leadership and with attention to health and health care.¹⁰² Some state level and national reproductive justice and immigrant justice organizations also address farmworker reproductive health concerns such as the National Latina Institute for Reproductive Health,

California Latinas for Reproductive Justice, ACCESS Women's Health Justice, and the National Coalition for Immigrant Women's Rights.

Adding reproductive justice to reproductive health and reproductive rights

Advocates of reproductive justice distinguish the framework or approach from two related approaches to women's reproductive health: the reproductive health framework and the reproductive rights framework.¹⁰³ Migrant health clinics exemplify the reproductive health approach in that they focus on the health status of farmworker women, identify the central problem as the lack of access to health care services, and thus concentrate their efforts on providing better access to services. Most current efforts to improve the reproductive health of migrant farmworker women embody this reproductive health approach. Migrant health clinics, the Migrant Clinician Network, the National Center for Farmworker Health, Health Outreach Program, and similar groups embrace this services-oriented effort that also is strongly reflected in NACMH's 2010 recommendations to the Secretary of Health and Human Services. The stated goal of these recommendations is to reduce barriers to health care access, by 1) expanding the comprehensiveness of services offered at current health centers by offering additional dental, behavioral and mental health services, as well as making services culturally and linguistically competent, 2) adding health centers, increasing outreach, and developing methodologies to better study the farmworker population, and 3) improving health information sharing among centers via new technology.¹⁰⁴

Farmworker legal advocacy organizations reflect the reproductive rights framework that focuses on farmworkers' legal rights to health services and related labor legislation as the primary means to improving farmworker women's health. In contrast to the relatively well-resourced reproductive health approach, legal advocacy on behalf of the reproductive rights of farmworker women as a group is uncommon and related legal services are relatively scarce. Local legal aid societies inform individual farmworkers of their rights and offer legal services to those in need, most often related to employment discrimination, sexual harassment, and domestic violence.¹⁰⁵ The Bandana Project—the Southern Poverty Law Center's public awareness campaign about violence against farmworker women—displays

decorated cloth bandanas to educate the public and to create solidarity among migrant women and others affected by violence.¹⁰⁶ Legal Momentum (formerly NOW Legal Defense and Education Fund) builds on its historical involvement in the passage of Violence Against Women Act with its Immigrant Women Program which offers public education about immigrant specific legal provisions, works to influence immigration policy, and provides training on “the rights of immigrant victims of violence, domestic abuse, exploitation and sexual assault.”¹⁰⁷

Despite their different approaches, the reproductive health and reproductive rights frameworks have similar core characteristics. Both respond to the needs of individuals with services for individuals. Both assume that access to more services—health and/or legal—will improve reproductive health. Both rely on professional expertise from outside the farmworker communities to improve health.

The reproductive justice framework argues that these reproductive health and reproductive rights efforts, while critical in addressing immediate needs, are ineffective in making long term change because they neglect the root causes of health problems: the myriad social inequities that control and regulate farmworker women and their communities. The reproductive justice framework does not replace these other frameworks, but rather engages with them in adding critical structural and intersectional dimensions imperative for achieving health and rights.

That said, structural change is difficult, particularly in the US health context. Such change requires long-term efforts that produce few visible short-term results. As a result, advocates for farmworker reproductive health often turn their energies to more evident actions such as offering health care or legal services that may obscure the root social inequities of reproductive oppression. For example, the Farmworker Justice report “HIV/AIDS and Farmworkers in the US,” offers an unusually comprehensive analysis of HIV risk factors: behavioral, social, cultural, and structural factors including disparate power, poverty, social discrimination, racism, and homophobia.¹⁰⁸ Yet virtually every report recommendation calls for expanded health care services, such as routine HIV testing, preventive education, condom use promotion, and treatment coordination, without responding to the structural risk factors also

named.¹⁰⁹ Similarly, “The Reproductive Health of Migrant and Seasonal Farm Worker Women” outlines a wide range of “reproductive health challenges” facing farmworker women, but focuses on expanding community outreach (more services in a new location) as the solution.¹¹⁰ Nonetheless, these limited implementation efforts do not abandon the fundamental goals of reproductive health, rights, and justice.

Interestingly, nearly four decades ago, Budd Shenkin, an early physician-administrator of the federal Migrant Health Program, argued that the political and economic powerlessness of migrant farmworkers was the root cause of their poor health, and thus that power relations in health care needed to be addressed.¹¹¹ He noted that “Migrant and Seasonal Farmworker Powerlessness” was the title of 16 days of hearings held by the Senate Subcommittee on Migratory Labor of the Committee on Labor and Public Welfare, 1969-1970.¹¹² This critical attention to power was reiterated by Slesinger in the early 1990s, but today, power disparities continue to be neglected by the reproductive health approach that dominates migrant health efforts.¹¹³ That said, signs that some health care providers are willing to address power relations and structural inequities appear, for example, in Heffington’s call for practitioners to examine their complicity in supporting the “large and unfair power differential” in the farmer-farmworker relationship, and in Kugel and Zuroweste’s rich analysis of the multi-faceted oppression of farmworkers.¹¹⁴

Certainly, Luz benefited from reproductive health and rights efforts that had helped make abortion legal and supported the presence of women’s reproductive health clinics. That said, these efforts did not enable Luz to prevent her unwanted pregnancy. As in 1978, female farmworkers today experience reproductive oppression rooted in poverty, unfair and unhealthy labor conditions, anti-immigrant bias, sexual and other violence, inadequate education, as well as a lack of access to reproductive health and legal services.

REPRODUCTIVE JUSTICE: ANALYTICAL OBSERVATIONS

Having engaged the reproductive justice framework to begin to understand the nature of just reproductive health for migrant women farmworkers in the US, I now explore this framework’s contributions and limits, highlighting five core assumptions, methodological features, and questions important

to considerations of migrant worker justice—reproductive and otherwise.

First, the reproductive justice framework takes as one of its starting points the claims of injustice made by those experiencing injustice, in this case, migrant women farmworkers. Not only do these women identify reproductive oppression, but they also give specificity and meaning to reproductive justice, and create and implement strategies for achieving it. For theorists working on global and transnational gender justice the reproductive justice framework requires engaging those affected persons to a degree now uncommon in academic work. As such this article represents only an initial examination of what reproductive justice might mean for migrant farmworker women, and affirms the women of Alianza Nacional de Campesinas and other such groups as authorities about their experiences of oppression and their visions of reproductive justice.

Second, the reproductive justice framework makes the ontological assumption that women are simultaneously powerful agential individuals and integral community members whose welfare is directly related to that of their communities. Whereas migrant women farmworkers surely experience transnational “gendered vulnerability,” the reproductive justice framework emphasizes that these women are also definers of justice and organizers for social change, in other words, are powerful moral, social, and political agents despite the power inequities they experience.¹¹⁵

Third, the reproductive justice framework’s understanding of oppression relies on accurate information about farmworker lives. In this way, the framework aligns with the calls of feminist bioethics and public health ethics for a “rich empiricism” in ethical analysis.¹¹⁶ The scarcity of research and resultant data about farmworkers is a serious obstacle to identifying oppression, and simultaneously, a sign of that oppression. Recent ethnographic research of marginalized groups in feminist ethics suggests ethnography as a fruitful method of gathering and producing this critical information.¹¹⁷ This work has been well initiated by Blackwell with Líderes Campesinas and Zavalla’s research on the lives of Mexican migrants in Santa Cruz County, California.¹¹⁸

Fourth, the reproductive justice framework defines reproductive oppression comprehensively, and thus

requires an intersectional understanding of the underlying social inequities producing reproductive oppression. For example, labor histories of farmworkers as well as their present locations in the transnational movement of labor are crucial to accurately naming and assessing reproductive oppression. So, too, is a recognition of the mutual reinforcement of anti-immigrant bias, class prejudice, ethnic discrimination, and gender stereotypes.¹¹⁹ Understanding this intersectionality is also critical for an effective envisioning of and strategizing for reproductive justice.

The final observation suggests an area ripe for further development. While the human rights discourse in Cairo was initially inspirational to the reproductive justice movement, the subsequent reproductive justice literature attends little to what has become a vast and mature body of human rights principles, actions, and critical discussion.¹²⁰ Is this health and human rights discourse an ongoing source of theoretical grounding for reproductive justice? Or are these now overlapping and mutually reinforcing conversations? Ultimately both are capable of enduring contributions to reproductive health, rights, and justice for US migrant women farmworkers and their communities.

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